Health Information Technology Policy Committee
Summary of the February 17, 2010, Meeting

Participants

David Blumenthal, Chair	HHS/National Coordinator for Health Information Technology
Paul Tang, Co-Chair	Palo Alto Medical Foundation
Christine Bechtel	National Partnership for Women and Families
Jim Borland	Social Security Administration
Neil Calman	The Institute for Family Health
Adam Clark	Lance Armstrong Foundation
Judy Faulkner	Epic Corp.
Art Davidson	Denver Public Health Department
Paul Egerman	Businessman/Entrepreneur
Gayle Harrell	Former Florida State Legislator
Charles Kennedy	Wellpoint, Inc.
David Lansky	Pacific Business Group on Health
Deven McGraw	Center for Democracy and Technology
Marc Probst	Intermountain Healthcare
LaTanya Sweeney	Carnegie Mellon University
Tony Trenkle	Centers for Medicare and Medicaid Services
Micky Tripathi	Massachusetts eHealth Collaborative
Larry Wolf	Kindred Healthcare
Scott White	1199 SEIU Training and Employment Fund
Connie White Delaney	University of Minnesota/School of Nursing
Jodi Daniel	HHS/Office of the National Coordinator
Judy Sparrow	HHS/Office of the National Coordinator

KEY TOPICS

1. Call to Order

Judy Sparrow welcomed Committee members and reminded the group that this was a Federal Advisory Committee Meeting, and thus was being conducted in public.

2. Opening Remarks

David Blumenthal, National Coordinator for Health Information Technology, welcomed the group and noted that this meeting marked an important point in the implementation of the Health Information Technology for Economic and Clinical Health Act (HITECH) and in the deliberations of the HIT Policy Committee. This group's assistance has been helpful in designing the Meaningful Use rulemaking paradigm and in moving the rule to its final form. The rule is dynamic and likely will undergo revision in several years, which will provide an opportunity for the Committee's review in the future.

3. Review of the Agenda

HIT Policy Committee Co-Chair Paul Tang reviewed the day's agenda, and then asked for and received approval of the minutes from the last meeting (held on January 13, 2010).

> **Action Item #1:** The Committee approved the minutes from last meeting by consensus.

4. Meaningful Use Workgroup: Comments and Discussion on the Notice of Proposed Rulemaking (NPRM)

Paul Tang presented 12 recommendations proposed by the Meaningful Use Workgroup. Participants discussed the recommendations in clusters: 1-4; 5-8; 9-11; and 12.

Recommendations 1–4

1. Reinstate Health Information Technology Policy Committee (HITPC) recommendation to include progress note documentation for EP Stage 1 meaningful use
2. Remove "core measures" from Stage 1
3. Reinstate HITPC recommendation to stratify quality reports by disparity variables
4. Providers should maintain up-to-date lists (not just one-time entries).

The discussion that followed included the following points:

- One Committee member suggested that clarification is needed regarding what constitutes progress notes. In the simplest form, progress notes are physicians' and nurses' notes. The intent is to incorporate clinical documentation into the electronic system and eliminate paper records. It is unclear, however, whether a drawing constitutes progress notes. The inclusion of notes for ambulatory settings could present particular challenges. The EHR and IFR include the capability for flexibility to handle more challenging scenarios.

- Some recommendations require changes that will have significant impact on workflow processes. Marc Probst commented that hospitals may encounter difficulties in their attempt to adhere to recommendation #4.

- When asked about the collection of either race or ethnicity data, Paul Tang explained that recommendation #3 encompasses the collection of both race and ethnicity as the best means to measure, understand, and address health disparities. The goal is to report quality measures.

- It was noted that the certification is intended to certify that data are getting into the EHR, regardless of the point of entry into the system (e.g., billing system or attending physician).

Recommendations 5–8

5. Reinstate HITPC recommendation to include recording of advanced directives for Stage 1 meaningful use
6. Reinstate HITPC recommendation to include patient-specific education resources for Stage 1 meaningful use
7. Reinstate HITPC recommendation to include clinical efficiency measures for Stage 1 meaningful use
8. Centers for Medicare and Medicaid Services (CMS) should create a glidepath for Stage 2 and 3 meaningful use.

The discussion that followed included the following points:

- Deven McGraw said in response to a question from Charles Kennedy that e-prescribing presents longer term challenges in following recommendation #7.

- Recommendation #7, bullet 3, the word "entered" was changed to "ordered."

- Marc Probst noted that recommendation #7 focuses on drugs, but other clinical efficiencies, such as imaging, are high-cost areas.

- The question of how to measure patient education (recommendation #6) was raised. In many EHRs, the act of prescribing education can be documented. Self-attestation also is possible.

Recommendations 9–11

9. CPOE should be done by authorizing provider
10. Amend prevention/follow-up reminders criterion to apply to a broader range of the population and allow for provider discretion in targeting reminders
11. Clarify "transitions of care" and "relevant encounters."

The discussion that followed included the following points:

- A discussion ensued about the term "authorizing provider." Marc Probst encouraged a clearer definition of the term, including whether it refers to the primary care physician or attending physician. Neil Calman observed that the process varies across states; in some states, both residents and students place the ordering. He added that part of the teaching process includes delegation, and authorization should be clarified for this. Marc Probst also requested clarification on dealing with the authorization of verbal orders. Paul Tang replied that verbal orders must be countersigned. The intention of recommendation #9 is to ensure that alerts and other feedback are provided to the authorizer.

- Gayle Harrell expressed concern that addressing method and accountability issues would increase the workflow process, and thus impede the adoption of the EHR. The importance of avoiding the unintended consequence of inefficient workflows for the sake of attaining meaningful use was emphasized. David Blumenthal noted that the EHR exists to help make better health decisions, not to fix other parts of the health care system.

- It was suggested that recommendation #10 may prove difficult to achieve, as it implies an existing body of knowledge. Paul Tang responded that the provider chooses the priorities.

Recommendation 12

12. Allow some flexibility in meeting meaningful use criteria (see table below)

Priority Area	**# objectives that may be deferred by EP or hospital (all EPs and hospitals must fulfill "mandatory" objectives)**	**Mandatory objectives (all EPs and hospitals must meet these)**
Improving quality, safety, efficiency, and reducing health disparities	3	• Have demographics recorded as structured data • Report ambulatory/hospital quality measures to CMS or the States • Use CPOE/Use of CPOE for orders (an type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP) • Generate and transmit permissible prescriptions electronically (eRx)
Engage patients and families in their health care	1	• Patients discharged are provided electronic copy of their instructions and procedures
Improve care coordination	1	• Test EHR capacity to electronically exchange key clinical information
Improve population and public health	1	
Ensure adequate privacy and security protections for personal health information	0	• Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

The discussion that followed included the following points:

- Paul Tang indicated that because it was assumed that all eligible hospitals are working on all requirements, the favored approach was to be flexible regarding the achievement of meaningful use criteria. Specifically, the approach is to defer the fulfillment of some criteria from Stage 1 to Stage 2.

- Members reached consensus about the need for flexibility, and all agreed that all privacy and security criteria must be met without exception. Charles Kennedy expressed concern about the complexity and need for transparency. Gayle Harrell commented about the high standards set for providers. Deven McGraw and Christine Bechtel noted the need to balance progress with achievability and suggested the possibility of partial-payment of incentives for criteria not fully reached.

- The group discussed the issue of working to meet the criteria versus not commencing work at all in Stage 1 on deferred criteria. Neil Calman reminded members that the Phase 2 process (2013) is unclear but that none of the current criteria are expected to disappear in the future.

Art Davidson observed that the message to the states and local communities is to prepare for these requirements. David Lansky pointed out that the capabilities to handle drug safety and efficiency may need additional attention. Marc Probst said that some criteria may be too aggressive, particularly regarding CPOE; in addition, meaningful use should be defined through a 5-year perspective, and greater flexibility should be given in achieving the goals.

- The Committee discussed whether the priority area "Engage patients and their family in their health care" should allow one or no deferred criterion. Regardless of any criterion deferral in this category, the patient still can access his/her EHR. LaTanya Sweeney asked what benefits are realized if no deferral of criteria is allowed in this priority area.

- The Committee voted on Recommendation 12, and then voted on the number of flexible criterion allowed for each priority area. Paul Tang summarized the results, which modified the table from 3-1-1-1-0 to 3-0-1-1-0. Committee members were invited to submit additional comments for inclusion in the draft letter (i.e., Recommendation 12 was modified based on 3-0-1-1-0, and some mandatory requirements were also changed).

Action Item #2: The Committee approved Recommendations 1-11 proposed by the Meaningful Use Workgroup.

Action Item #3: The Committee approved Recommendation 12 proposed by the Meaningful Use Workgroup in favor of a low number of mandatory criteria along with flexibility for deferral.

5. Adoption/Certification Workgroup: Comments and Discussion on the NPRM and the Interim Final Rule (IFR) on Certification

Marc Probst and Paul Egerman presented three recommendations proposed by the Adoption/Certification Workgroup regarding the NPRM, and provided the Workgroup's comments and concerns about the Interim Final Rule (IFR) on Certification.

Recommendations regarding the NPRM included the following:

- Greater detail is needed on how to calculate reporting metrics for items involving the percentage of electronic usage versus manual usage.

- The IFR should include certification criteria for a section called "Reporting Metrics," which would ensure automatic calculation of all metrics that are required to be reported.

- The reporting process for Stage 2 of Meaningful Use should not require manual review of records or subjective judgments.

The Workgroup was pleased with the Committee's response to the Workgroup's 2009 recommendations, including: the focus on meaningful use; specifying that LOINC and RxNorm is a significant forward step toward interoperability; emphasis on privacy and security; and emphasis on modular systems.

The Workgroup had concerns about the IFR Interoperability Statement and recommended that certification for interoperability should be leveraged, with the government providing leadership in critical areas where the use of mature standards may not exist and implementation specifications (guides) being designated with a plus. In addition, the Workgroup supported the Health Information Exchange Workgroup's recommendations to extend use of HL-7 2.5.1 for laboratory exchange. Greater specificity of interoperability standards is needed, including the adoption of a single standard for exchange or explanation by the ONC regarding why more than one standard was specified and the circumstances for which a particular specification should be used. The Workgroup also recommended that a transition plan be established or a transition statement be made regarding how certification will be handled until the new process is put into place.

Participants were invited to attend the HIT Safety Hearing scheduled for Thursday, February 25, 2010. Topics for review include identification of issues, stakeholders, and possible approaches.

The discussion that followed included the following points:

- Deven McGraw commented on the need to maintain balance regarding the standards for interoperability; standards that are too regimented will block innovation. She supported ONC's decision to provide clarity as particular situations arise.

- Charles Kennedy encouraged the Workgroup to consider in its transition plan ways to involve intermediaries or health plans potentially for eligible provider measures, such as eligibility status and claim status. He also suggested that existing data collection processes (e.g., Healthcare Effectiveness Data and Information Set [HEDIS]) could be leveraged as an intermediate step. The Workgroup's letter will include the question of using other sources of information and receiving further guidance from CMS.

- Jodi Daniel said that the interim final rule is final, but changes could be made as comments are still being accepted. Also, the ONC has been collaborating with the National Institute of Standards and Technology (NIST) during the past several months to develop test tools for the certification criteria, and the expectation is that it will be released for feedback and for vendors to consider in their efforts to attain certification.

- Gayle Harrell said that the certification process should ensure that the EHR accomplishes all required calculations, rather than placing the burden on physicians; otherwise, the risk is great for non-adoption of the EHR. This should be addressed through the certification process. The Workgroup recommended this and the writing and embedding of appropriate software programs by vendors should be accomplished by 2011. Gayle Harrell also encouraged greater flexibility as vendors face challenges in producing a certified product quickly if certification requirements are not finalized until 2011.

Action Item #4: The Committee approved the recommendations proposed by the Adoption/Certification Workgroup.

6. Information Exchange Workgroup: Comments and Discussion on Health Information Exchange in the NPRM

Deven McGraw and Micky Tripathi provided contextual information that supported the rationale for the Workgroup's recommendations that directly affect laboratories and recommendations that are indirectly affected by the recommendations for laboratories. Changes recommended to the NPRM and IFR include that, in Stage 1: (1) laboratories should adopt the HL-7 2.5.1 Implementation Guide; (2) HL7 2.5.1 certification criteria for hospital lab reporting should be extended to all lab result reporting; hospitals should demonstrate this capability; (3) HL-7 2.5.1 content exchange standard in certification criteria should be included for EP and hospital EHR technology; and (4) options for public health reporting content exchange and vocabulary standards should be reduced or the circumstances in which each of the standards would be required should be explained. Also in Stage 1, the eRX measure should be refined to account for markets in which 75 percent eRX may not be possible. In Stage 2 for both the NPRM and IFR, signal requirements for ordering should be established.

Deven McGraw described the Workgroup's recommendations for ONC actions. The ONC should support efforts to release the Clinical Laboratory Improvement Amendments (CLIA) Survey and Certification Letter as soon as possible, particularly because CLIA is policy lever that can be used more aggressively to persuade laboratories to achieve compliance more quickly. In addition, ONC has worked closely on these rules with Centers for Medicare and Medicaid Services (CMS) and its support of stronger CLIA guidance will bolster HHS' efforts overall to promote standardization of laboratory results. The State HIT Coordinator should be required or encouraged to work with state CLIA administrators to align state-level laboratory approach with national CLIA, standards, and certification requirements. Federal and state employee health programs could require contractors to use such standards.

The ensuing discussion included the following points:

- Tony Trenkle requested additional details on how to address the drug prescription situation throughout the country while avoiding significant administrative obstacles. Micky Tripathi said that the CMS has a tremendous amount of data that could be carved up geographically that might yield a more meaningful denominator for practitioners. CMS regions also could be used, but pharmacies might not be ready to receive the data because of the lower penetration rate in terms of prescribing. There could be two categories to separate urban (for which 75 percent e-prescription reporting is reasonable), and rural (which requires greater leniency because of reduced population levels and lower pharmacy penetration). Another issue is raised by which pharmacy the patient wishes to fill the prescription. Jim Borland said that the IFR provides the answer of "75 percent of the possible." Neil Calman said that if it is too complicated, then the threshold should be reduced to a realistic percentage; he recalled that Phase 1 is to build a capability. A participant commented that one aspect of this is to encourage 100 percent prescription via the EHR, and a second component involves the reporting requirement out of the EHR, including on prescription activity.

- Charles Kennedy asked whether e-fax counts as an electronic prescription. Consensus was that it does not although this is not stated explicitly.

- Gayle Harrell said that the provider frequently has no control over these issues (patients make the decisions) but the penalty is on the provider.

- Art Davidson commented that, in extending HL-7.2.5.1, the certification criteria to all laboratory reports from hospitals, the place where certification occurs may make a difference. An example is if the HIE servicer arranges for the hospital to send the information as 2.3.1 and then the HIE servicer converts it to 2.5.1; the potential exists to achieve the goal but not be certified at the hospital. Paul Tang indicated that this should still count, provided a modular, certified EHR technology is used to meet meaningful use. LaTanya Sweeney added that the modular approach might benefit from an examination of manufacturing models.

- The Stage 1 recommendations for laboratories do not require that hospitals transmit their data in structured format but rather that they adopt and test the format. This aligns the process with the public health requirement. Some hospitals may refrain from transmitting anything structured to avoid requirements, but it is expected that market incentives will facilitate the process. This recommendation allows a transition time for hospitals.

> **Action Item #5:** The Committee approved the recommendations proposed by the Health Information Exchange Workgroup.

7. Privacy and Security Policy Workgroup: Comments and Discussion on the Privacy and Security Objective in the NPRM

Deven McGraw, Chair of the Privacy and Security Policy Workgroup, reminded the Committee that the objective of Stage 1 is to protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities, and that the Stage 1 measure is to conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary. She said that the Workgroup developed two categories of recommendations: those that strengthened existing criteria and those previously proposed that involved the meaningful use requirement to comply with HIPAA Privacy and Security Rules as a Stage 1 objective.

Recommendations To Strengthen Existing Criteria

- Make clear that for EPs and Hospitals who have never conducted a HIPAA security risk analysis, the requirement is to conduct such an analysis (not review).
- Make clear that meaningful use criteria regarding uses of health information do not override existing state or federal law setting parameters around access, use, and disclosure of health information.
- Provide guidance to EPs and Hospitals on how to conduct an appropriate security risk assessment.
- Clarify what is meant by "implement security updates as necessary."
- Attestation for meaningful use should be two-fold: (1) the risk analysis was conducted or reviewed; and (2) the entity has mitigated risks identified.
- Attestation should be reinforced through audit.

Recommendations Regarding Meaningful Use Criteria Originally Approved by the Policy Committee To Be Restored

- Restore MU requirement to comply with HIPAA Privacy and Security Rules as a Stage 1 Objective, per next recommendation.
- Establish that EPs and Hospitals have not met MU privacy and security objectives if they have been found liable (or guilty) and fined for a significant civil or criminal HIPAA violation.

Deven McGraw described the Workgroup's concerns regarding the IFR and future policy and standards priorities. Concern was expressed about standards and capabilities not included for 2011. The Workgroup will continue its work to identify privacy and security policy priorities for which standards or technical capabilities are needed with the expectation that these priorities can be addressed by the Standards Privacy and Security Workgroup and the Standards Committee in 2010. The Workgroup recognized the NHIN Workgroup's upcoming activity to work in greater detail on privacy and security policy issues such as authentication and identity across a network, and a trust framework, and it looked forward to working closely with the NHIN Workgroup to develop recommendations that establish a strong and accountable trust framework for the secure exchange of data across networks. Similarly ONC, through its state Health Information Exchange grant program, should advance consistent interpretation and implementation of additional privacy and security requirements.

The discussion that followed included the following points:

- Tony Trenkle expressed support for strengthening existing HIPAA rules and regulations and asked about penalization of hospitals in general. The Workgroup focused solely on privacy and security as related to meaningful use. In general, penalties are enacted for the payment year during which a violation occurred. Systemic problems are dealt with through the HIPAA system.

- Tony Trenkle requested clarification about specific instances, such as non-encrypted data on laptops. The strengthening criteria are administrative in nature and pertain specifically to meaningful use and IFR. A question was raised about whether the recommendations concern the rule itself or how to implement or enforce the rule.

- Neil Calman encouraged exceptionally concrete and clear communication using simple language, as the general population's response to legal terminology may pose a potential public relations issue.

- Art Davidson asked about the role of CMS and Medicare agencies in auditing. Paul Tang answered that their role depends on the type of audit conducted. The audits should prove that people attest to what occurs. There is a need to determine cost and size; however, this encompasses a larger scope than just meaningful use.

- Christine Bechtel asked about recommendation #2 ("Establish that EPs and Hospitals have not met MU privacy and security objectives if they have been found liable [or guilty] and fined for a significant civil or criminal HIPAA violation."), and whether that is a high enough

bar given that some entities may have violated privacy or security objectives but have not yet been fined. Deven McGraw responded that this recommendations is what the Workgroup agreed to.

- Gayle Harrell cautioned about public perception of providers and said that EHR adoption will not occur without public trust.

- Members were informed that the ONC is not limiting its interest in privacy and security to meaningful use. These recommendations will have the effect of pushing everyone to monetary settlements as the largest HIPAA fine is $1.5 million. Providers face a significant public relations issue if they are investigated.

Action Item #6: The Committee approved the recommendations proposed by the Privacy and Security Policy Workgroup to strengthen existing criteria.

Action Item #7: The Committee approved the recommendations proposed by the Privacy and Security Policy Workgroup to restore the meaningful use requirement to comply with HIPAA Privacy and Security Rules as a Stage 1 objective.

8. NHIN Workgroup: Recommendations

David Lansky, Chair of the NIHN Workgroup, presented the Workgroup's recommendations. He noted that the Workgroup was charged with creating a set of recommendations for a policy and technical framework for the NHIN in a way that is both open to all and fosters innovation. Key findings in Phase 1 included that critical elements need to be in place to achieve meaningful use in 2011, such as: secure Internet transport; directories to allow parties to definitively route information the intended participants; means to authenticate and validate the identity of parties involved in information exchanges; and trust fabric to reassure all parties that the exchange can be accomplished successfully. Recommended topics for Phase 1 include meaningful use, transport versus content, directories, and authentication and identify proofing. Phase 2 addresses the role and function of enabling organizations within a trust framework. The Workgroup's findings encompassed standards and services, policies for confidence assurance, and the role of government. Next steps include identity proofing and authentication, directories, trust fabric, and governance.

Discussion included the following points:

- Paul Tang the enabling org could include vendor organizations. Because the American Recovery and Reinvestment Act (ARRA) included a special requirement that extended to the vendor organization, a vendor who chose to be an enabling organization could end up being a business associate under those circumstances. Members were informed that because HIE is not defined, the business associate term is applicable to vendors and presents a regulatory matter. David Lansky noted that the vendor's qualification as a

business associate depends on the vendor's function in the process. A breach of a vendor's directory services could have wide-ranging implications.

- David Blumenthal thanked the Workgroup for its efforts. He asked whether the Workgroup intended to continue to its September/October timeline before preparing recommendations for the states. Guidance could help states use their funds for HIE. David Lansky replied that the Workgroup's best recommendations will be forthcoming in 2 months.

- Gayle Harrell noted that the State of Florida already has published requests for proposals (RFPs) and she encouraged the release of the recommendations soon.

- David Lansky said that states have not been instructed regarding how to structure or govern within the state. All of the states should participate in the NHIN process from the planning process onward. The states are expected to lead the process toward uniformity and not simply perform HIE.

- It was noted that anything that the Workgroup or ONC recommends should be able to be accomplished with the existing HIE specifications. This is an opportunity to engage with the existing specifications and in the process of creating new technical specifications.

- Jim Borland pointed out that the NHIN has used models for governance for more than 1 year and operating procedures are well established. The next step may be to broaden accessibility to the current specifications and standards.

- Marc Probst asked about federal guidance regarding consent (e.g., opt-in and opt-out). Jodi Daniel said that the Privacy and Security Workgroup is developing a workplan that will include recommendations on this topic in the spring.

9. Update: Strategic Plan Workgroup

HIT Strategic Framework Workgroup Chair Paul Tang, and Co-Chair Jodi Daniel, presented an update on the strategic plan process. They reminded members of the proposed themes and objectives, and shared strategies developed by the Workgroup. The strategies for each theme are as follows:

1. Meaningful Use of HIT

- Identify or endorse key national health priorities for which effective use of HIT has demonstrated impact or has high potential to improve health outcomes. Use these priorities to guide selection of future criteria for assessing the meaningful use of HIT.
- Develop a progressive meaningful-use roadmap—from data capture and exchange, to advanced clinical processes, to improvement in health outcomes.
- Actively support primary care providers to achieve meaningful use of certified EHR technology.

- Align, coordinate, influence, and prioritize public- (federal and state) and private-sector HIT efforts that support health care professionals and hospitals achieve meaningful use of HIT to improve health outcomes.
- Measure HIT adoption and meaningful use toward improving health outcomes.
- Effectively train and increase the number and capacity of the workforce capable of supporting adoption and implementation of HIT in communities.
- Promote effective use of HIT to support care communication and coordination among consumers and their health care professionals.
- Promote participation of all health care professionals, including those not eligible for meaningful use incentives, in achieving meaningful use and improving health outcomes.
- Promote increased usability in certified EHR technology and other HIT products.

2. Policy and Technical Infrastructure

- Adopt standards, implementation specifications and certification criteria that incrementally enhance the interoperability, functionality, utility, and security of HIT and that support its meaningful use.
- Establish and maintain a certification program for purposes of performing testing and certification of EHR technology.
- Assess the need for and implement, as appropriate, policies and programs related to other HIT products and solutions in addition to EHRs.
- Enable exchange of electronic health information to support evolving meaningful use criteria and a learning health system.
- Assess and address patient safety concerns that may arise from HIT.
- Support the expanded use of innovative technologies (e.g., telehealth, mobile health) that support care communication and coordination among consumers and their health care professionals.
- Collaborate with Federal partners to expand broadband access to support health and health care.

3. Privacy and Security

- Assess and implement, as appropriate, federal policies related to key privacy and security issues.
- Review existing privacy and security laws to identify the need for potential modifications and policies to align with emerging HIT and health information exchange capabilities.
- Explore and promote existing and emerging technologies to enhance privacy and security.
- Coordinate and engage with States on privacy and security and health information exchange policies.
- Develop and promote specific best practices and guidance for hospitals and health care professionals on the implementation of privacy and security policies defined in the *Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information*.
- Include privacy and security policies in meaningful use criteria and adopted standards, implementation specifications, and certification criteria.

- Promote an environment of accountability through public education and effective and fair enforcement of legal requirements.
- Develop and maintain a national education initiative to broaden the national dialogue on privacy and security issues and to enhance public transparency regarding the uses of protected health information and individual's rights with regard to protected health information.

4. Learning Health System

- Continuously evaluate successes and lessons learned through HIT adoption, and actively incorporate best practices into the HITECH HIT programs and services.
- Reward, showcase, and leverage industry best practices, innovative uses of HIT to create active learning in the US health system.
- Support research and development activities to overcome obstacles that impede creation of learning systems.
- Engage federal and community stakeholders in coordinated activities to advance population health (e.g., public health, biomedical research, quality improvement, emergency preparedness) by using common policies, standards, protocols, legal agreements, specifications, and services for data sharing and building knowledge.
- Develop and implement educational material and tools to improve consumers' health literacy and healthy behavior using HIT.
- Communicate with professional societies and boards to identify opportunities for meaningful use activities to contribute to professional education programs.

A discussion followed, which included these highlights:

- David Blumenthal said that he was impressed with the efforts of all the Workgroups, noting that today's presentations exemplify the complexity involved and the interdependencies among the components.

- David Blumenthal welcomed concrete suggestions regarding the Learning Health System strategy to "Develop and implement educational material and tools to improve consumers' health literacy and healthy behavior using HIT."

- Jim Borland said that the focus of meaningful use on measurable results may fold into the strategic plan.

- Neil Calman encouraged the Workgroup to connect the Meaningful Use in HIT (Theme #1) strategies more closely to the objectives. He noted that the objectives did not mention the public health component of meaningful use. In addition, next steps should be developed for potential legislative fixes for missed opportunities (e.g., provider groups, including pediatrics, psychiatrists, and ambulatory care, left out).

- Christine Bechtel encouraged the Workgroup to reexamine Theme 2 and make the interplay between policy and standards (Theme 2, strategy #1) more explicit; the policy foundation for this strategy currently is a sub-bullet of strategy #4.

- Theme 2, strategy #4 focuses on policies and their components that enable health information exchange, and several of the sub-bullets also encompass capacity. The Workgroup was encouraged to include contextual information to better indicate the purposes for the strategy.

- Christine Bechtel suggested that Theme 3, strategy #8 should be more broadly construed to describe privacy and security in the context of communication and coordination.

- It was noted that a role exists for the government, and particularly ONC, in the long-term strategy to transform HIT systems. LaTanya Sweeney added that HIE can provide technical harmonization, and she queried about economic sustainability with a new workforce.

13. Public Comment

Zorba Paster, St. Mary's Hospital, related anecdotal experience related to privacy and the electronic medical record. He stated that they have concluded that they cannot ensure that the medical record can be guaranteed "cleaned" of any diagnosis. To do so would inevitably lead to a lack of trust by the patient, family and public. They do not encourage the "opt out" choice – just encourage "truth in labeling" – either "opt in" or "opt out" of the entire record – all or none.

SUMMARY OF ACTION ITEMS:

Action Item #1: The committee approved the minutes from last meeting by consensus.

Action Item #2: The Committee approved Recommendations 1–11 proposed by the Meaningful Use Workgroup.

Action Item #3: The Committee approved Recommendation 12 proposed by the Meaningful Use Workgroup in favor of a low number of mandatory criteria along with flexibility for deferral.

Action Item #4: The Committee approved the recommendations proposed by the Adoption/Certification Workgroup.

Action Item #5: The Committee approved the recommendations proposed by the Health Information Exchange Workgroup.

Action Item #6: The Committee approved the recommendations proposed by the Privacy and Security Policy Workgroup to strengthen existing criteria.

Action Item #7: The Committee approved the recommendations proposed by the Privacy and Security Policy Workgroup to restore the meaningful use requirement to comply with HIPAA Privacy and Security Rules as a Stage 1 objective.